EXHIBIT 17

PLEASE DO NOT DETACH

United States Medical Licensing Examination™

UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)
STEP 1 AND/OR STEP 2 EXAMINATIONS

ADMINISTERED TO STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS BY
THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, 3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, USA
PHONE: 215 386-5900 · CABLE: EDCOUNCIL,PHA

PART A

NOTE: All items on all sides of the application must be filled out completely for initial and reexamination or application will not be accepted.
Use typewriter or block print in ink.

① ECFMG EXAMINATION HISTORY:
Have you ever submitted an application to ECFMG for any examination, even if you did not take the examination? ☑ Yes ☐ No
If yes, enter your USMLE Identification Number (ECFMG Applicant Number) in this box: 0-553-258-5

② NAME: Print your name as you want it to appear on the Standard ECFMG Certificate and on your official USMLE record
First Name: JIOHIN
Middle Name:
Last Name (Surname): AKIODIA MOSIA
Full Maiden Name (For married women only):

②.1 If you have previously applied to ECFMG under another name, provide that name
Previous Name:
Please include a copy of the legal document that verifies this name change.

③ ADDRESS: Use address to which admission permit and other notification from ECFMG should be sent
Number/Street: 5180 10 QUANTRELL AVENUE
Apartment Number: APT NO 8110
Post Office Box Number:
City: ALEXANDRIA
State/Country: VIRGINIA
Zip or Postal Code: 22312

④ U.S. SOCIAL SECURITY AND/OR NATIONAL IDENTIFICATION NUMBERS:
Enter U.S. Social Security Number:
Enter National Identification Number and Country:
Country:

⑤ STATUS OF MEDICAL SCHOOL STUDENT: *Must* be completed by students.
If you are applying for Step 1, will you have completed two years of medical school by the date of that examination? ☑ Yes ☐ No
If you are applying for Step 2, will you have completed or be within 12 months of completion of the formal didactic curriculum at your medical school by the date of that examination? ☐ Yes ☐ No

⑥ REGISTRATION: Select no more than one box for each Step and/or ECFMG English test for which you are applying.

Step 1 (Check one box only)	Step 2 (Check one box only)	ECFMG English Test (Check one box only)
☐ June 11-12, 1996	☐ March 5-6, 1996	☐ March 6, 1996
or	or	or
☑ October 15-16, 1996 LATE	☐ August 27-28, 1996	☐ August 28, 1996

⑥.1 TEST CENTER: Select three different ECFMG centers in order of preference for each Step and/or ECFMG English Test. See the information booklet to which this application was enclosed for a list of ECFMG centers.

If your center selections are not available, ECFMG reserves the right to assign a center.

Step 1: (1) NEW YORK 330 (2) NEW YORK 330 (3) _____ City _____ Center No.

Step 2 and/or ECFMG English Test: (1) _____ City _____ Center No. (2) _____ City _____ Center No. (3) _____ City _____ Center No.

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⑦ EXAMINATION FEE(S): Enter the amount enclosed on the line provided

Fees must be paid in United States funds. Checks, bank drafts or money orders are to be made payable to the ECFMG. Do not send cash.

Step 1 Basic Medical Science Examination	$440
Step 2 Clinical Science Examination	$440
ECFMG English Test	$ 40

Enter amount enclosed $ PAID/Credit

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⑧ HANDEDNESS: ☑ Right Handed ☐ Left Handed

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ECFMG_RUSS_0000643

PART B

(9) SECONDARY SCHOOL/ COLLEGE UNIVERSITY ATTENDED:

List any secondary school, college, or university attended.

Name / City/State/Country	Dates Attended From MO.	From YR.	To MO.	To YR.	No. School Years
University of Benin. Nigeria	10	81	10	87	6yrs
KINGS COLLEGE LAGOS NIGERIA	06	74	06	79	5yrs

(10) MEDICAL DEGREE AND (10.1) MEDICAL SCHOOL:

Title of Medical Degree: M.B.B.S. Date Conferred/Expected: * MO. 10 YR. 87

* If the degree has been conferred, a photocopy must be sent to ECFMG. See *Medical Education Credentials* section of the ECFMG Information Booklet.

Name of Medical School from which you graduated or expect to graduate. LIST EXACT NAME AND ADDRESS.

Name / City/State/Country	Dates Attended From MO.	From YR.	To MO.	To YR.	No. of Years Attended
UNIVERSITY OF BENIN. EDO STATE NIGERIA.	10	81	10	87	6

(10.2) OTHER MEDICAL SCHOOLS ATTENDED:

Name / City/State/Country				

(10.2) CLINICAL CLERKSHIPS:

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
	See Part D of this application for entering clinical clerkships.			

(11) MEDICAL LICENSURE: Present or Future

Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine: MO. 01 YR. 89

Country or state in which you are licensed: * NIGERIA

* If the license has been issued, a photocopy must be sent to ECFMG. See *Medical Education Credentials* section of the ECFMG Information Booklet.

(12) HOSPITAL TRAINING: Residency or fellowship

Hospitals	Position(s)	Dates

(13) EMPLOYMENT: Present employment only

Institution/Company	Position	Dates
Name:		
Street:		
City/State/Country:		

(14) BIRTHDATE/ BIRTHPLACE:

Day 01 Month 01 Year 59 Location: BENIN, CITY EDO STATE, NIGERIA
City, Province, Country

(15) GENDER:

Please check one: ✓ Male ___ Female

(16) NATIVE LANGUAGE: EDO

(17) CITIZENSHIP:

(Complete all three)

A. AT BIRTH NIGERIAN USA ☐ or Other ☐ (Specify) _____

B. UPON ENTERING MEDICAL SCHOOL USA ☐ or Other ☐ (Specify) _____

C. NOW NIGERIAN USA ☐ or Other ☐ (Specify) _____

(18) OTHER EXAMINATION HISTORY AND APPLICANT NUMBERS:

Check below the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.

ORGANIZATION	DATE OF MOST RECENT EXAMINATION TAKEN MO.	YR.	APPLICANT IDENTIFICATION NUMBER
☐ NATIONAL BOARD OF MEDICAL EXAMINERS		19	NBME Parts I/II
		19	USMLE Steps 1/2
☐ STATE LICENSING AUTHORITY IN THE UNITED STATES		19	FLEX — FEDERATION IDENTIFICATION NUMBER (FIN)

PART C

ECFMG-000644

☐ STATE LICENSING AUTHORITY IN THE UNITED STATES

MO. | | YR. | 1 | 9 | | |

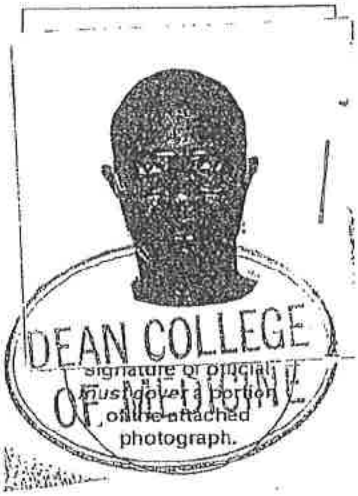
PART C

Students and graduates must sign the application in the presence of their Medical School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) *and* must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.



⑲ **CERTIFICATION BY APPLICANT**

I hereby certify that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition (that which pertains to the administration for which I am registering) of the combined Information Booklet on ECFMG Certification and Application for USMLE Step 1 and Step 2 examinations and USMLE Bulletin of Information, am aware of the contents of both sections and meet the eligibility requirements set therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See Information Booklet for additional details concerning Validity of Scores and Irregular Behavior.)

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

RECEIVED
AUG 30 1996
ECFMG

Signature of Applicant (In Latin Characters) X Johanna Koda Date 8/29/96

⑲.1 **CERTIFICATION BY MEDICAL SCHOOL OFFICIAL**

OR

CERTIFICATION OF IDENTIFICATION WITH EXPLANATION (Pertains to graduates only)

A. I hereby certify that the photograph, signature, and information entered on Section 10 of this form accurately apply to the individual named above.

X _____
Signature of Medical School Official (In Latin Characters)

Dean of College 7/7/96 Boston
Official Title Date Institution

B. I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 19 _____.

X _____
Signature of Consular Official, First Class Magistrate, Notary Public (In Latin Characters) Official Title

B.1 Explain in the space below why the application could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

FOR OFFICE USE ONLY	
FORM	DATE
S.A.	
I.D.	
338	
339	
325	
R	M 9/11/96

⑳ Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked? ☐ Yes ☑ No

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

㉑ Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information; however, the processing of your application will not be affected if you choose to leave item ㉑ blank.

Select the one which best describes your racial/ethnic background.

1 ☐ American Indian/Alaskan Native
2 ☐ Asian Pacific Islander
3 ☐ Hispanic
4 ☑ Black (not of Hispanic Origin)
5 ☐ White (not of Hispanic Origin)
6 ☐ Other

ECFMG-000645

PART D

(10.2) CLINICAL CLERKSHIPS: Refers to that period of medical education in the clinical disciplines during which as a medical student you gained practical experience in hospitals or clinics.

List clerkships (rotations, pre-graduate internships) for each clinical discipline.

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
medicine	specialist Hosp. Benin	warri	Dr Omwuka	1988
Pediatrics	specialist Hosp Benin	warri	Dr Asemota	1987-1
OBGyn	specialist Hosp Beni	warri	Dr Iyinta	1988
Surgery	specialist Hosp Benin	warri	Dr Idahosa	1988